

## Spirometry Facility Certification Form

NIOSH  
Coal Workers' Health Surveillance Program  
1095 Willowdale Road, M/S LB208  
Morgantown, WV 26505

Facility Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Street Address \_\_\_\_\_ Email \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Type of Facility (Mobile, Clinic, Private Office, Hospital) \_\_\_\_\_ How many spirometries per year? \_\_\_\_\_

### Spirometry System(s) Used

Unit #1

Unit #2

Room Number (if applicable)	_____	_____
Manufacturer	_____	_____
Model	_____	_____
Serial #	_____	_____
Date acquired	_____	_____
Spirometer Validation Letter* (attached)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Automated Quality Control*	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Calibration Check Available*	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Graphical Displays		
Meet 2005 ATS/ERS size standards*	<input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume	<input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume
Real-time during testing*	<input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume	<input type="checkbox"/> Volume-Time <input type="checkbox"/> Flow-Volume
Test Report for Interpreter* (sample attached)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Spirometry data file		
Stores 2005 ATS/ERS parameters*	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Stores all maneuvers	<input type="checkbox"/> Yes <input type="checkbox"/> if No, max # _____	<input type="checkbox"/> Yes <input type="checkbox"/> if No, max # _____
Electronic Output Format*	<input type="checkbox"/> 2005 ATS/ERS <input type="checkbox"/> NIOSH-approved	<input type="checkbox"/> 2005 ATS/ERS <input type="checkbox"/> NIOSH-approved

### \*Items indicated by asterisk are required

**Spirometry procedure manual** available in laboratory ☐ Yes (mo/yr revised \_\_\_\_\_) ☐ No

**Ongoing spirometry quality assurance program** ☐ Yes (mo/yr revised \_\_\_\_\_) ☐ No

**Height Measurement Device** ☐ Stadiometer (brand) \_\_\_\_\_ ☐ Other \_\_\_\_\_

**Weight Measurement Device** ☐ Medical scale (brand) \_\_\_\_\_ ☐ Other \_\_\_\_\_

Name(s) of Spirometry Technologist(s)	Copy of NIOSH-Approved Spirometry Certificate attached
_____	<input type="checkbox"/> Yes
_____	<input type="checkbox"/> Yes
_____	<input type="checkbox"/> Yes
_____	<input type="checkbox"/> Yes

I agree to participate in this program in the manner specified by Part 37 of the Code of Federal Regulations (42 CFR Part 37), and understand that all information used in connection with this program will be held STRICTLY CONFIDENTIAL and divulged only as specified by the above Regulation.

Supervising Clinician (copy of license attached)	Signature	Date Signed
_____	_____	_____

Clinician certification or specialized spirometry training Institution	Title of course or certification	Date completed
_____	_____	_____

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Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA, 30333, ATTN: PRA (0920-0020).